VOL. 14, NO. 1 MAY-JUNE, 1964

Inventory

A BI-MONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

PUBLISHED BY THE N. C. ALCOHOLIC REHABILITATION PROGRAM

TREATMENT

REHABILITATION

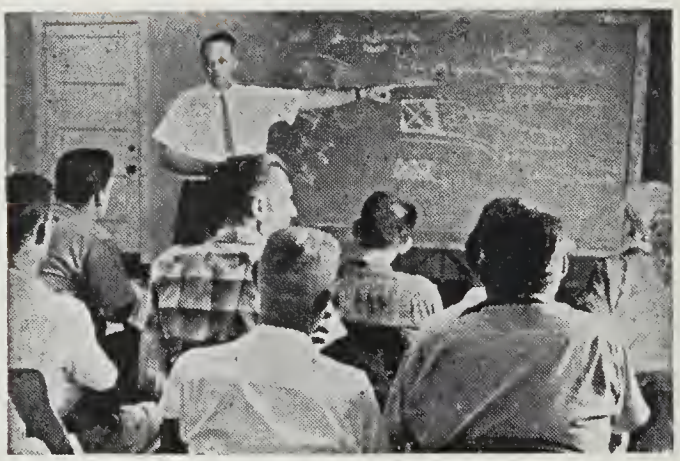
EDUCATION

PREVENTION

N. C. ALCOHOLIC REHABILITATION CENTER

BUTNER, N. C.

The N. C. Alcoholic Rehabilitation Center is a facility for the treatment of male and female problem drinkers who request admission. The Center is located at Butner, N. C., and is operated by the North Carolina Alcoholic Rehabilitation Program under the N. C. Department of Mental Health. Admission to the Center is strictly voluntary. The cost of treatment is $75 for 28 days' stay if the patient is able to pay.



Butner Treatment Methods

Treatment at the Center is by psychotherapy and consists of group discussions led by the professional staff, educational films, individual consultations with staff members, vocational guidance, recreation, rest, proper food and prescribed medications. Butner is staffed by the medical director, one other physician, a psychiatric social worker, psychologist, chaplain and admitting officer, vocational rehabilitation counselor, activities director, and a full attendant staff.

The Butner Patients

Patients must come to Butner of their own free will. No patients are accepted by court order. The patient who is sincere in wanting help and comes voluntarily to the Center stands a much better chance of a successful rehabilitation than the one who is pressured.

Entrance Requirements

1. Admission is by appointment in response to written or telephone request to the Medical Director of the Center, 406 Central Avenue, Butner, N. C., expressing voluntary desire for treatment. All appointments must be confirmed by mail and should preferably be made by the patient's physician or by other professional personnel in the patient's community, for example, alcoholism information center personnel.

2. A complete social history compiled by a trained social worker in the local Public Welfare Department or Family Service Agency, and a complete medical history, compiled by the patient's family physician, are necessary.

3. A fee of $75, in cash or certified check, must be paid upon admission if the patient is able.

4. Sign a letter-statement requesting voluntary admission at the time of admission.

It is especially important that patients applying for admission have a thorough medical examination and be in good physical condition at the time of their admission. The Center is not a hospital or a sobering up facility and patients desiring admission should have been sober for at least seventy-two hours and should not be exhibiting withdrawal symptoms. There are no facilities provided at the Center for the treatment of physical illness. Patients are expected to enter into the recreation program and to perform certain daily chores assigned to them. Patients with serious disabilities which would prevent their climbing steps are advised not to seek admission, inasmuch as sleeping quarters are on the second floor.

Admitting Hours

Wednesday, Thursday and Friday during the morning and afternoon. Patients may have visitors after they've been at the Center for 2 weeks. Visiting hours are from 1:00-4:00 P.M. on Saturday and Sunday.

ALCOHOLIC REHABILITATION PROGRAM

OF THE

NORTH CAROLINA DEPARTMENT OF MENTAL HEALTH

NORBERT L. KELLY, Ph.D.
Associate Director

NORMAN DESROSIERS, M.D.
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RALEIGH, N. C.

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ENTERED AS SECOND-CLASS MATTER AT THE POST OFFICE, RALEIGH, N. C.
UNDER THE AUTHORITY OF THE ACT OF AUGUST 24, 1912

FOR A PRICE

Anyone can drink if he's willing to pay for it, but for some people the price is exceedingly high.

THEY can't tell me what to do!

One of the things I hear most frequently by alcoholics trying to stay sober is that it makes them mad to be told that they can't take a drink. This comes out in dozens of different ways in group discussions. "Before the waitress got to me, my boss said, 'And bring Joe a coke'." "Honey, do you think you should play bridge with them—you know they'll all have a drink." These kind of remarks are repeated by the patient with all the hostile resentment you can imagine.

Why does it make them so mad? Because it is heard as "you **can't** take a drink." I challenge this! I say any alcoholic **can** drink any time he wants to. There's nothing to stop him. The only joker is that he'll have to **pay the price.** Sure he can drink—he just can't drink without getting into serious trouble in one or more areas of his life.

One of the most unrealistic or sickest things we see operating in an alcoholic's thinking is the idea that this time "I can drink without getting sick or causing family difficulty or losing the job," etc. This is pure wishful thinking—a refusal to face a proven reality. To say you are an alcoholic means that experience has shown that your makeup is such that when you drink it leads to serious difficulty.

Any alcoholic who can really accept the fact that for him alcohol equals trouble, rather than hanging on to the fantasy of alcohol equals pleasure, has passed one of the first major hurdles. If he can accept this fact, then he can see that it's not a matter of "you **can't** drink." Sure you **can** if you're willing to **pay the price.** The individual has a choice of whether he **wants** to drink or not.

There's much less room for self pity and resentment in not drinking when it's of one's own choice. The idea that "they'll think I'm not a man" doesn't make much sense when you look at it. Would you think anyone was less a man because he had strength enough to refuse to do something that he knew would put him in a position where he was incapable of caring for himself, much less his family? I think not!

I think this resentment at "being told" is just a sneaky way the subconscious has of trying to dodge the fact that he can't drink without getting into trouble. I know many individuals who have deeply accepted their relationship to alcohol. When they have done this they have become much more comfortable with not drinking. It is their choice not to drink and they realize that they have every

TWO SHORT-SHORT ARTICLES

BY VERNELLE FOX, M.D.

right to make this choice.

One man I know is in a business where he encounters much drinking. When a customer says, "Have a drink," he simply replies, "No, thank you, I don't have time." The first time he says this the customer usually says, "Whatta you mean you don't have time?" He then tells the guy that if he's going to drink, he wants enough to "do some good" and that this takes about a month and he doesn't have a month to spare right now. He tells me that he's rarely bothered the second time by the same customer insisting that he have a drink.

So it's all in the way you look at it. Anyone can take a drink if he's willing to pay for it. The trouble is that for some people the price is exceedingly high.

LOVE

The only love we can feel is that which is given. Love cannot be demanded or bought or controlled.

LOVE is the exclusive possession of the person doing the loving. It is his to give or not give, governed only by how he feels. It cannot be demanded or bought or controlled by anyone else.

One of the major difficulties of many people who have alcoholism is the inability to realize this. Time and again I watch them go through a desperate process that always ends in their feeling rejected and more alone. It's a vicious snowballing process. The more they feel alone and rejected, the more they demand love and the more they feel rejected.

Oh, it's a subtle process and the people involved seldom understand the trap they're in. You don't have to understand a trap to feel it! The patient, like all the rest of us, wants and needs to feel loved. Usually he is full of self-doubt and guilt feelings and, therefore, not at all sure that anyone could love him. This creates a desperate feeling that pushes him to demand, in a million little ways, love and attention. When he demands evidence of love from those around him and they try to give it to him, he doesn't believe it.

Since these expressions of love are in response to his demands, he's not quite sure that they are genuine. This increases even more his need to be proven to that he's loved. This goes on and on until the one from whom love is being demanded feels crowded and controlled and will instinctively push the loved one away. So everyone is frustrated. The patient finds what he suspected in the first place. "They don't really want me, they push me away." This wife, or whoever it is, is equally frustrated because she loves him and wants to show it. But love is something that must be given and she cannot give it if he's always taking it away from her before she gets a chance.

Many people feel that the ones they love do not love them. What they don't realize is that they themselves lack the external security to allow themselves to be loved. Again the only love we can feel is that which is given to us. That which we extort is not satisfying. If this same man could sit back and wait a little, his wife could show him that she loves him. He needs to give her room to move in as it were.

Have you ever really watched a baby? We could all take lessons from him. He's a past master at "suffering himself" to be loved. He crawls around in his own busy little world, but if you notice he's got one eye on you all the time. Practically nobody can resist his indifferent charm. You just feel compelled to love him a little. He obviously eats it up and it makes you feel good to see how he enjoys your affection and attention. But when the time comes that you must put him down, he goes back to crawling around in his own busy little world—quite secure that you or somebody else will very shortly feel compelled to love him a little. He can wait because he knows that people have just as great a need to give love as they have to be loved.

Someone doesn't love you because you have earned it or demanded it—or even because you're lovable. They love you out of their need to give love. On the other hand, it comes voluntarily, not when it's in response to your demands.

These articles, originally published in *The New Life,* are reprinted by permission of the author who is medical director of the Georgian Alcoholism Clinic.

Youth and Alcohol

I have long been an interested reader of your excellent publication, *Inventory,* as well as being aware of your very fine state program on alcoholism. Your January-February, 1964 issue was particularly interesting with two articles on Youth and Alcohol most interesting. I noticed that the entire proceedings of your 1962 conference on Youth and Alcohol are available. I would be grateful to receive a copy in order to get new ideas and thoughts for our annual conference we hold each year for youth.

Gordon E. Larson
Executive Director
Alcoholism Council of
the Monterey Peninsula
Carmel, California

Help For AA Group

As secretary of the New South AA group I have been requested to write and see if you can place our group on your mailing list for future copies of *Inventory.* We have approximately 25 active members and could use 10-12 copies for distribution and discussion in our meetings. We find the articles in *Inventory* quite helpful and stimulating.

Anonymous
High Point, N. C.

Nursing Student Writes

I am a Junior nursing student at East Carolina College School of Nursing. This quarter I am studying, among other subjects, preventive medicine. Several days ago my instructor stated that we, too, as students could receive your magazine. Please add the following name to your mailing list.

Dora A. Brown
Greenville, N. C.

Wants Additional Copies

Will you kindly send me five additional copies of your current *Inventory* containing "Clues to the Diagnosis of Alcoholism." Thanks for your wonderful, helpful magazine.

State Hospital
Marlboro, New Jersey

Alcoholism and Tuberculosis

Yesterday I received my copy of the March-April, 1964 *Inventory* which I have already read. Working in a tuberculosis hospital, I was especially interested in the article entitled, "The Physician's Role in the Treatment of Tuberculosis-Alcoholism" written by Dr. Donald J. Ottenberg. I thought the article was especially good and would like very much to have twelve copies of *Inventory* sent to me so that I can distribute these issues to our physicians. Unfortunately, we have a number of these who know very little about the illness of alcoholism and I have endeavored to stimulate some interest since we have a considerable number of patients here who have serious drinking problems. I am hopeful that someday our physicians will receive more orientation in regard to the medical problems of alcoholism and will be more understanding of our alcoholic patients.

Anonymous
New York

INVENTORY

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ARTICLES AND FEATURES OF INTEREST ON ALCOHOL AND ALCOHOLISM

PREVIOUSLY advocated as the first step in the adoption of a company alcoholism program has been the formal recognition of alcoholism as a medical, treatable illness, by establishing this concept in the form of an equally formal policy statement to that effect.

This philosophy, although seemingly ideal, has not held up in actual practice. Many business organizations are unwilling, even after months of intensive educational-level contact, to adopt such a policy without some form of internal verification of the value of affording their problem drinkers treatment. And reasonably so.

This verification procedure, unconscious as it may be, serves a purpose in that it provides the company with the opportunity to observe the treatment agency and its "product." This observation procedure, in turn, assists the company in its trial-and-error approach to the problem of alcoholism as it affects its own internal workers, both short-term and long-term.

Company Policy and the Alcoholism Rehabilitation Agency

By ALLAN H. DANA

INDUSTRIAL CONSULTANT

FLORIDA ALCOHOLIC REHABILITATION PROGRAM

Too much stress has been given to the adoption of formal company alcoholism programs; the informal program merits the attention of those companies with less formal organizational needs.

This article, reprinted by permission of the author, originally appeared in a report by the North American Association of Alcoholism Programs.

Statistics are available which provide rates of successful treatment for alcoholics referred to treatment by industry. The "state of the art" of industrial services work has improved in the past few years to the point where many treatment agencies have formally declared the extent to which they can go in offering developmental and consultative services to business and industry. Lectures, seminars, personal contacts and other educational work have helped to establish many working relationships between the agency and local businesses.

However, the standards by which successful industrial services work has been judged have not been based upon the realities of the business community: Particularly the realities of management policy making. Entirely too much stress has been laid at the door of the formal policy statement. The long-term value (to both the agency and the company) of the informal policy—the unwritten law which guides the company—has been almost totally ignored.

Basically, policies are guides by which the organization delimits its activities in the various spheres with which it is concerned. There are personnel policies, production policies, marketing policies, research policies, and many other levels including those general policies pertaining to employee health and welfare.

Attention to the health and welfare of a firm's employees may logically come under the area governed by personnel or production policies. Within these areas, specific concern may be further manifested in terms of safety, absenteeism, efficiency, insurance, pension, morale, productivity, and so on. However, regardless of the specific policy areas in which an alcoholism treatment agency could conceivably be interested, the fact remains that policies are derived according to the specific needs of a business enterprise and according to the need for a specific type of policy.

What most alcoholism rehabilitation agencies have failed to recognize is the fact that several types of policy exist and that the formal written policy does not appear to be the better method in attempting industrial services work. The agencies have also been occupied with looking for "the best way," when their concern should be with a "better way."

Policies exist on two levels—formal and informal. There are, further, two types of formal policy; the internal kind enunciated by top management and the kind imposed by an external source, such as a regulatory agency. The first is the kind which has been given too much attention and which, it appears now, has been less than effective. The need to alter this traditional thinking is apparent and depends upon an ability to recognize the merits of the informal approach to policy making.

The informal approach to policy making, like the formal, is based upon the need to improve the company environment. But certain essentials must be considered here also; essentials which consider all aspects of the business. For example, the Florida Alcoholic Rehabilitation Program considers a company alcoholism program to be a two-phased "product:" (1) a program of prevention and control of alcoholism which is effectuated through a procedure for early identification and referral to treatment; and, (2) an attention to the health and welfare of the employees which is both necessary to and consistent with the profit motive. The program has gone one step further, too, and attempted to empathize with the business community. It is they who, when ap-

proached by an external force, must base a decision on such factors as: (1) the existing need; (2) the risks involved; (3) modification of existing systems; and (4) the reward for adoption.

Liaison between the agency and the company can only provide superficial answers to the questions prompted by attention to these factors: answers based upon a rather unscientific observation of what others have done. But does the need to prevent and control problem drinking exist on all levels of the same company? In establishing a procedure of identification and control, does company A run the same legal, monetary, labor relations, or production risks as does company B? Must the existing systems of first aid, training, and personnel relations be so modified by the adoption of an alcoholism program as to preclude most of its value to a company? Are the rewards commensurate with the planning, organizing, coordinating, and controlling efforts required for an effective alcoholism program?

Perhaps these can all be simply answered in the affirmative and we can return to our standardized approach. I doubt that "yes" is the answer and that industrial services work will reach its optimum effectiveness so long as the efficacy of informal policies is ignored. It is in this power to produce effects that the value of informal policy lies.

Informal policy results either consciously or unconsciously when a pattern of management decisions results in an acceptable code of organizational conduct. This code exists mainly as an attitude rather than a paragraph in the company's handbook and has, traditionally, guided decision-making with greater vehemence than possible with the formal, written statement. Since industrial services seeks to alter outmoded approaches to problem drinking, such modification might well be better approached via informal, attitude-modification which first permeates the thinking of management and eventually manifests itself in an acceptable code of company conduct, rather than the reverse.

Industrial services work has been putting the cart before the horse—putting the need for a formal policy before both the required attitude change and the better means of achieving that end. The important point concerning policy is that the pattern of attitudes which comprise a business enterprise must be carefully assessed from a realistic point of view. Otherwise, the results of an agency-company relationship could well be the very suspicion, complacency, and even negativism with which we have been concerned in the first place.

The Florida Alcoholic Rehabilitation Program will continue working toward adoption of formal company alcoholism programs where formality is both required by a particular company structure and plausible for the agency-company relationship. However, the informal policy must not be negated in its value to companies with less formal organizational needs. The informal policy can serve as the initial phases of a formal company alcoholism program or it can act as the final shape of an alcoholism program where formality is neither required nor feasible. Many times it is the only way open for effectuating a working relationship between a governmental agency and a private enterprise.

This is just one of the areas of industrial services work which requires scrutiny if the growth so vital to alcoholism rehabilitation is to be achieved.

A NEW CAGE

Alcoholism is a new label for an old cage—the drunk cage—but cages aren't changed by changing labels. We must build a new cage to fit the new label.

BY RALPH DANIEL
EXECUTIVE DIRECTOR
MICHIGAN STATE BOARD OF ALCOHOLISM

THERE is an old, old story about a man who was hired by a small circus to wear an ape skin and pretend to be a wild animal. They put him in a cage. At first, he enjoyed the job. He enjoyed having people look at him. He enjoyed entertaining people. Time went on and he became more and more like the animal he pretended to be. Sometimes, he even thought of himself as an animal.

Then, one day, someone failed to bolt the gate between the lion cage and the ape cage. The lion, who incidentally had never appreciated his neighbor's masquerade, came stalking into the ape cage. The ape man, thinking as an ape, tried to climb out of reach of the lion but quickly found that the confines of his cage prohibited this type of escape. In desperation, he yelled for help.

The lion sprang on him, wrestled him to the floor, and whispered in his ear, "Shut up, you fool! Do you think you are the only man pretending to be an animal?"

Each of us lives in a sort of cage and there are different types of cages. Our cages help to determine what we are and the way we act. The signs people see when they look at our cage may read, "doctor," "lawyer," "merchant," "chief," "housewife," or "laborer." We tend to become what we think our sign signifies. Sometimes, we need a shocking experience to make us realize that we are primarily human beings like the people who live in other cages and that our differences are superficial.

At birth, through no choice of our own, we entered a cage that differed from the cage that we would have entered had we been born of a different sex. We found that our world expected different things from males than it expected from females. It granted certain freedoms of expression, if we were born male. It expected more sensitivity, if we were born female. We grew in this cage and it helped to make us what we are. Sometimes we choose our cages, sometimes we drift into them, and sometimes we are forced into them. No matter how we get in them, our lives adapt to the cages we live in.

The readers of *Inventory* are primarily concerned about persons who have drifted into a cage bearing a new label—"Alcoholism." For a while, it may be smart to think about the cage instead of the "animal" inside.

"Alcoholism" is a new label for an old cage. We have yet to build a cage that fits the new name. Curious sightseers look at this cage as they looked at it before when the sign said, "DRUNK (a chronic inebriate)." The onlookers see the same type of "animals" inside. The normal reaction is one of "Smart people speak of drunks as 'alcoholics'. So what?" The crowd of onlookers includes doctors, ministers, nurses, employers, lawyers, social workers, legislators, councilmen, some people who "occaionally drink too much," and many others. Perhaps we should post a new sign—"TEMPORARILY HOUSED IN THE DRUNK CAGE WHILE MORE SUITABLE QUARTERS ARE BEING DESIGNED."

We built a cage for drunks because they threatened our general welfare. They resign from society and neglect their responsibilities. By "due process of law," we lock them up and take away their privileges. Our cages provide some hiding places but when the "animals" come out where we can see them, we tease them, toss them peanuts, laugh at them, or we stare with a sort of idle curiosity. This is the cage from which we are now try-

ing to rescue alcoholics.

Most of the alcoholics we know are at least partially a product of the drunk cage. They have seen what the onlookers do to the drunks that come out in the open, so they hide and try to prove that they are not like the obvious drunk; and slowly but surely they become more and more like the others. We have learned much about getting selected alcoholics out of the drunk cage. We know very little about the alcoholic who never faced the stigma of the drunk cage. We don't know what an alcoholic would be like if everyone recognized the early symptoms of alcoholism as warnings of a progressive illness. Perhaps we should try to find out about the effect of a new cage before we invest too much in the rescue from the old cage. We may, someday, find ourselves with ultra modern methods of making horseshoes for a world that rides on rubber. We could even be guilty of preserving the drunk cage because we know so much about rescue.

Just suppose that everyone looked on drunkenness as we now look on a bleeding wound. Suppose everyone recognized the difference between normal and abnormal drinking. Suppose every person who showed early symptoms of alcoholism recognized them as warnings of ill health rather than omens of the stigma of the drunk cage and something to be hidden. Suppose the illness was considered respectable and there was no reason to "admit," "deny," or "become anonymous." These are the things that we must build into the new cage. They may well produce an entirely different "animal."

Alcoholism experts may go the way of the blacksmith. Alcoholism hospitals may be converted to something else. Alcoholism clinics may close their doors. The people and the facilities that now treat people with other respectable illnesses may well hang up the welcome mat for alcoholics.

Every alcoholism agency and every interested citizen might well concern themselves with the task of building a new cage to house a newly recognized "animal' with a man inside. We cannot diminish our efforts to help those who are in the "Drunk" cage, but we must not accept this as the ultimate goal. We must plan for a suitable cage and expect it to produce a patient instead of an animal.

The key to cage building is communication. It is the need to move an idea and a knowledge from a few people to many people. Communicators frequently make the mistake of underestimating the distance between themselves and the potential listener. They forget that there are language barriers among people who apparently speak the same language.

We say, "Alcoholics are sick people," and we get peeved because doctors, nurses, employers, ministers, families, friends, social workers, judges, and lawyers don't suddenly start treating them like sick people. Changing the label on the cage does not convince the sightseer.

Our world judges a drunk by the actions it sees. The alcoholic may look like a drunk and he may act like a drunk. Perhaps our sign should read, "ALCOHOLIC—Often Mistaken for a Drunk by Those Who See Only Symptoms." We must not expect to change cages by changing titles. We must prove a man is inside.

Some of us are primarily interested in a specific alcoholic and not in alcoholism or in alcoholics in general. We, too, are building a cage that may need alterations. Our alcoholic lives in a cage made by those he lives with and those he has lived with in the past. Cage alterations are not easily made—nor are they impossible.

The first step to cage improvement is an honest look at our own expectations. What does the label, "Alcoholic," mean to the people who live with this particular alcoholic? Let's take a minute to consider this question. If "alcoholism" means abuse, unpaid bills, lost work, neglected responsibilities, and drunkenness, then we only kidded ourselves when we changed the name to alcoholism. If alcoholism means what the alcoholic *does,* then we might just as well put back the old "DRUNK" sign. We get upset not because alcoholism ruins our lives, but because the results of alcoholism ruin our lives. We must not build cages to protect ourselves from the results of alcoholism. It's the man inside that must be considered. He must be considered as a person and not a collection of symptoms.

Many physical problems have symptoms that affect the lives of those who live with the victims—but we don't generally blame the victim or mistake the symptom. Running sores, vomiting, bed-wetting, crutches, wheel chairs, plaster casts, invalids, and crying or complaining can be upsetting to those who live with the sick, but we take them in our stride and see the sickness, not the symptom. We cannot honestly use the "alcoholism" sign until we can see the difference between the sickness and the symptoms.

Just suppose we do recognize that our lives are being ruined by the *results* of alcoholism and that our alcoholic does not want these results any more than we want them. This may be the first cage alteration that we make. It does not guarantee that our alcoholic will accept the sickness idea, but it may help.

Most alcoholics consider alcohol as a problem solver and a sort of "do-it-yourself" medication. They see the things we call symptoms as unpleasant side effects. Doctors know that some medications are contra-indicated (not good for some patients). Sometimes they weigh the side effects and decide that the cure is worth the bother. Our "do-it-yourself," self-treating alcoholic may be making the same decision. He (or she) probably doesn't realize what he is doing and he will resent our telling him. What do we do now?

First of all, we must face the fact that he (or she) may never change. Some physical and emotional results of illness are permanent. Amputated legs don't grow back. Death is permanent. A mentally ill patient may spend the rest of his life in a hospital. Some people remain invalids for the remainder of their lives. People who are close to alcoholics, and who want to build better cages, must ask themselves, "What would I do if I knew there would be no change?" There are alternatives.

Some wives and husbands make good lives for themselves and their children while married to untreated alcoholics. Sometimes, an employer can tolerate irregular work records and pay for the services of a "half man." Sometimes parents can protect an unproductive "child" as long as they live. Sometimes these things are not possible.

In most states, treatment can be forced by law. Our laws and our courts and our physicians and our hospitals are not always fully aware of the meaning of the new sign on the cage. The value of forced treatment will improve as society begins to grasp the meaning. (This is a challenge for our most competent cage constructors.) There are many degrees of force. Legal involuntary commitment is one of them. The threat of losing a job, home, family, social status, or physical health are

(Continued on page 31)

WHEN I was asked who in Con Edison might be willing to come to Cleveland and talk about alcoholism in industry, I decided to take the assignment myself. I could have suggested that Dr. S. C. Franco, executive director of our Medical Department, come instead. He is far more qualified to discuss the medical, psychological and psychiatric technology of alcoholism. On the other hand, I think you will be interested in the point of view of the layman of what the impact of alcoholism might be on the income statement, of how we must change personnel procedures, seek out and find the alcoholic in the early stages, and of the public relations aspect of the frank recognition that alcoholism is a problem and that it behooves top management to do something about it.

Alcoholism does have an effect on the income statement, but like the alcoholic himself, much of it is hidden. The direct effect can be measured; the indirect effect cannot. The Rutgers Center of Alcohol Studies recently estimated that alcoholism costs American industry somewhere around $2 billion dollars a year.

The direct costs are those of absenteeism, separation allowances, early annuities or pensions. The indirect costs are those involving absenteeism, inefficiencies, not only of the alcoholic himself, but usually carrying over to his whole work group, overtime payments to the people who perforce do the alcoholic's work, work improperly done, and work paid for but just not done at all.

I shall not give you a figure of what we think the *direct costs* are because it might seem pretty small in relation to total payroll expense. Suffice it to say that for every dollar we at Con Edison spend in ferreting out the hidden alcoholic and attempting to rehabilitate him, we save two dollars—and I emphasize that this saving is based on only the direct measurable cost.

A company alcoholism program can salvage the skill and experience of long service employees, save money, and contribute to an overall improvement in employee relations.

This article was originally presented as a talk at a meeting on alcoholism in industry sponsored by the Cleveland Chamber of Commerce, Cleveland, Ohio. March 10, 1964. It is printed in *Inventory* by permission of the author.

In December, 1947, Con Edison officially recognized chronic alcoholism as a medical condition and adopted a Procedure on Alcoholism. The decision was based on the policy that we would meet the problem openly instead of perpetuating the outworn pretense that it did not exist.

Now, if I refer to Con Edison frequently in the next few minutes, I do so because I shall use its Procedure on Alcoholism and the experience gained from it as a case study and I shall tell you something of its successes and failings.

As a background, I shall give you a brief description of Con Edison. It is a relatively old Company among utilities. It began back in 1823 with the introduction of manufactured gas for illumination. Then in 1882, Thomas Edison built his first electric generating station on Pearl Street. Shortly before this, steam service had been made available in certain parts of Manhattan. Over the years, a number of companies were organized and eventually absorbed into what is now Con Edison, which supplies energy

A FORMAL COMPANY POLICY

An Industrial Program for *Recognition and Control* of Alcoholism

BY CHARLES B. DELAFIELD
VICE PRESIDENT
CONSOLIDATED EDISON COMPANY OF NEW YORK

in the form of electricity, gas and steam to much of the New York Metropolitan area.

We have a payroll of some 25,000 people, recruited from all races, creeds and colors, to do the job. Our employee body contains a large percentage of individuals with long records of service and experience. Many families have worked for us three or more generations.

Some unusual conditions prompted us to take a look at the health of our employee group right after the close of World War II. Returning veterans sought their old jobs, mergers had scrambled executives and a group of youngsters were pushing for recognition. These conditions set the stage for some disturbing situations for anyone lacking in emotional stability.

Our medical director at that time was Dr. John Wittmer and he was able to translate to top management definite areas of concern; he convinced top management that, among other matters, chronic alcoholism was a Company problem and should be recognized as such. In recognizing chronic alcoholism as a medical condition—or accepting the concept of alcoholism as a disease—we mean that while it has a common denominator with other illnesses, that is, help must come from an outside source, it *does* differ in that there is an element of personal responsibility in the development of alcoholism. Obviously a "sick absence" due to acute intoxication cannot be equated with illnesses due to acute infection or cardiovascular disease.

Any Company program for alcoholism must be based on a sound industrial relations approach to the problem. At Con Edison the forthright recognition of problem drinking was coupled with a program for rehabilitation. The past 17 years have proved that this approach was worthwhile. An increasing number of employees have been restored to economic usefulness and case absenteeism has been reduced. Also, it has been adequately demonstrated that the early recognition of a drinking problem offers the best opportunity for successful rehabilitation.

Recognition implied that we must also provide the means for rehabilitation particularly since community facilities were practically non-existent. We also knew that without an opportunity for rehabilitation, the program would develop into an out-

right disciplinary measure and would be doomed to failure.

If we were to follow solely a disciplinary course I am sure that our own supervisory people as well as union officials would try to protect the early alcoholic thus assuring his eventual downfall.

At Con Edison, however, we find that the average length of employment is about 22 years and that it is among the group with about 15 years experience, mainly between the ages of 46 and 54, where alcoholism is generally found. Thus, the problem drinker represents a serious human and public relations problem.

The separation or retirement of employees with this type of experience, with otherwise fruitful years to serve the Company, frequently could mean the loss of key people. These employees are the relatively stable group in our Company and are far removed from the skid-row type of alcoholic.

From an operating standpoint, we think there are other broad benefits to be obtained. Every skilled employee we are able to keep through to normal retirement makes the personnel recruiting and promotion situation much more effective.

The operation of any company, I think you will all agree, is not just simply one of relying on the brains of top management. Training of replacements is not something that can be done in the classroom alone. New developments in our industry, we are satisfied, would never have been possible without a strongly oriented work force to provide the raw material for improvement.

In order to recognize the alcohol problem as we view it, some definitions may be helpful.

From an industrial viewpoint, we consider an employee to be an alcoholic when repeated or continued overindulgence in alcohol interferes with the efficient performance of his assigned duties. This limits the recognition of abnormal drinking to the area where it affects work performance, causes abnormal behavior on the job or results in absenteeism. The term "problem drinking" is often used synonymously with alcoholism. Technically speaking, this is considered to be an early stage in the development of chronic alcoholism.

We recognize two major types of alcoholics: (1) The habitual excessive symptomatic drinker. This condition is basically a reflection of the symptoms of a social situation. (2) The alcohol addict, whose drinking has the element of compulsion and whose condition appears to be based on an underlying psychological abnormality.

Addictive Drinkers

Originally, it seemed that the symptomatic alcoholic represented about 85 per cent of the "problem drinkers" in general. Over the years, however, *we* have become aware, through the studies of our medical people, that a type of "secondary" addiction can develop in the course of long-continued excessive drinking and that at least one third of our cases have become addicted alcoholics. Most of our failures in rehabilitation, I might add, have been in this group.

Alcoholism is a progressive disease and in a period of from two to 20 years the non-addictive drinker may pass from the pre-alcoholic phase to the establishment of chronic alcoholism with accompanying organic disease. The addictive alcoholic usually travels this road at a much faster pace and at an earlier age than the symptomatic drinker.

We have developed a "Profile on Alcoholism" outlining the progres-

sive stages which will help to illustrate what I've just said.

The profile form is made up in three sections. The front page lists the stages of alcoholism, and has a chart on which the subject's age can be graphically correlated. At the bottom of the page, diagnosis of the subject, as either a symptomatic drinker or an addictive drinker, appears. The left-hand page inside contains another chart on which the medical staff can follow up a patient's rehabilitation progress over a four-year period. The inside right-hand page contains the explanatory guides used by the doctors in grading the various stages of recovery.

Although the profile lists "Social Drinking" as stage one, it is included only as a reference point. As a matter of fact, stage two, "Dependent Drinking," does not indicate alcoholism unless the drinking is excessive and prolonged. Let me stress that alcoholism means different things to different people and manifests itself in different ways.

The stages "Pre-Alcoholic" (three), "Problem Drinking" (four), "Early Alcoholic" (five), "Chronic Alcoholic" (six) and finally, "Organic Deterioration' (seven) are all those of "alcoholism as we define it" and are listed as a means of further identifying the significant aspects for the doctor's analysis.

It is difficult for our medical people to separate the two types of alcoholics, the symptomatic drinker and the addict. Experience indicates that it is at about stage four—"Problem Drinkling"—that the types can be distinguished. By the time the alcoholic reaches stage six when he is known as "The Chronic Alcoholic," the characteristics of each type become distinctly noticeable. The addict is manifested by "benders," delirium tremens and hospitalization.

The final stage, which the profile form lists as "Organic Deterioration," involves the physical effects of severe cirrhosis, neuritis, and malnutrition.

In the first phase of our program at Con Edison from 1948 to 1951, the problem drinkers and early alcoholics constituted approximately 15 to 20 per cent of the group. Chronic alcoholics were close to 60 per cent of the total and the advanced alcoholics, with complicating disease, accounted for the remaining 20 per cent.

It is evident to us that alcoholism is largely a hidden disease. Some alcoholics are covered by certificates provided by family physicians. Others are hidden by industry itself because of the years of faithful service or the idea that there is no adequate treatment. This has given rise to the erroneous concept in some quarters that alcoholism need not be considered a problem in industry. It would seem obvious that management can not possibly have any accurate knowledge of the extent of the alcoholism problem unless there is actually a Company program in operation. Over the period of 15 years from 1948 to 1963 we have recognized 643 cases with a distinct drinking problem. We have averaged about 40 new cases each year under Company procedures. For every case that is recognized there is a hidden alcoholic who will be reviewed under the Disability Panel for disabling medical conditions which are attributed to chronic alcoholism.

This fact illustrates that administration of this program has not been without its own problems. Treatment is not completely adequate due to the gaps in present-day medical knowledge. Long-term rehabilitation still encompasses the danger of relapse. Even at this date, certain

(Continued on page 18)

UNDOUBTEDLY, the most remarkable company policy relating to the problem drinker, as seen by the writer, is that of Tropicana Products, Inc., located in Bradenton, Florida. Not only does this company adhere to a basic philosophy of humanitarianism, but it actively supplements its philosophy by hiring a percentage of its work force from the ranks of known alcoholics and parolees. This attitude has existed since the company's inception ten years ago, and has been reinforced by successful rehabilitative efforts since then.

Tropicana's efforts are doubly unique in the fact that no **formal** program for recognition and rehabilitation of the alcoholic employee exists. The basic premise upon which its activities are based is that both profits and humanitarianism can be, and are, unidirectionally combined. This is not meant to imply the indiscriminate employment of alcoholics, but rather the use of a flexible plan whereby the requirements of the company, the community, and the individual may be met on a common ground.

The system works in the following manner: A group of Bradenton business and professional men, and civic leaders, make themselves available for the purpose of assisting any alcoholic or parolee. The main emphasis of the group is in attending to the spiritual needs of the individual. Once an individual attains the recognition of his problem and a desire for positive action, he is referred to a local business for employment. Tropicana is active in this plan.

Upon referral to Tropicana, the individual is interviewed and completes a standard, extensive application form. If the general economic situation permits, and if there is a place in the organization for the individual, he is hired. At this point, however, several relatively uncommon activities occur. The first is that the newly hired individual's need for rehabilitation is considered paramount over and above his special skills, although the skills are considered when possible. The company recognizes the occasional relapse of the alcoholic, even while in treatment. In order that the relapse (or in the event of treatment failure, the prolonged "binge") will not interfere with the company's daily needs for its skilled employees, the problem drinker is generally hired to fill an unskilled job. Once rehabilitated, however, and providing an opening is available, he is placed in the job for which he has specific skill.

The second company characteristic which is uncommon to other programs dealing with the problem drinker is the absence of a formal supervisory training program on the subject. Supervisory meetings which are oriented toward the human relations aspect of foremanship are held, but because of a diversity of opinion among the foremen, neither formal training nor undue emphasis upon problem drinking are afforded.

There are, however, a number of supervisors (40 per cent) who have specific interest in and knowledge of the topic of alcoholism. Their willingness and desire to aid the problem drinker toward rehabilitation has met with considerable company encouragement and success. When an alcoholic is hired he is assigned to the department of one of these supervisors. If alcoholism appears in a present employee, he is transferred to the

AN INFORMAL COMPANY P

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This description of an informal company program was taken from Vol. 6, No. 1 of the *Research Reports in Social Science* published semi-annually by the Institute for Social Research, The Florida State University. This report, *Problem Drinking in Industry: A Study of Industry's Implications of Alcoholism in Florida,* by Allan H. Dana was published in 1963.

department of one of these foremen. Regardless of this humanitarian interest, though, the supervisor remains responsible to the company for his department's production, economy, and efficiency.

Mr. I. D. Turner, personnel director for Tropicana, estimates that alcoholism, as a medical disease, affects approximately two per cent of the company's annual average of 600 employees. In order to provide what the company considers as the most effective rehabilitation, this percentage is usually held at that level. The hiring of additional alcoholics is temporarily stopped when this figure is reached, since undue pressure upon the interested supervisors is not deemed advisable.

Aside from the previously mentioned group of Bradenton citizens who aid in the rehabilitation of the alcoholic and parolee, the company also encourages use, by the alcoholic, of the facilities available through Alcoholics Anonymous and the Florida Alcoholic Rehabilitation Program. Affiliation with any such group is not a condition of employment, but it is encouraged. Neither is the company directly connected with any specific rehabilitation agency, except to afford accessibility to such agency for its employees. Its own efforts, emphasizing the physical, moral, and spiritual needs of the individual, are communicated to the employees, and periods for personal consultation between the employee and management are afforded.

In the personal interview between this researcher and Mr. Turner, it was further discovered that some financial aid, in the form of a small loan, is available to the company's employees during the initial period of employment. No company funds are ever used to rehabilitate the problem drinker. Also, alcohol is never served at the various company functions, nor the company's salesmen allowed to use alcohol to entertain customers—it is not honored on the expense account.

From this writer's point of view, the plan utilized by Tropicana, although unique in many ways, is potent for several logical reasons. The company provides a false "bottom" for its alcoholic employees by temporarily negating the individual's skill in favor of the finances and responsibility of a job and the benefits of a rehabilitation plan—both extremely important to successful rehabilitation. The intense desire to help an individual is involved at all levels of management, from the presidential to the supervisory level. The company demands only that the individual be interested in helping himself.

It might be stated, in conclusion, that Tropicana's basic philosophy is "Business is business, but so is humanitarianism."

ICY

icana Products' Policy

BY ALLAN H. DANA
INDUSTRIAL CONSULTANT
FLORIDA
ALCOHOLIC REHABILITATION PROGRAM

Tropicana's management has the desire to help and the company demands only that the individual be interested in helping himself.

AN INDUSTRIAL PROGRAM

CONTINUED FROM PAGE 15

levels of supervision in our Company will not recognize that the problem exists. The hidden nature of chronic alcoholism itself continues to baffle early detection and a lack of medical facilities hampers an all-out attack on alcoholism in the community.

The basis of the Con Edison Company Procedure on Alcoholism is the use of a firm, judicious, probation policy which, in effect, puts job security in jeopardy and motivates the employee to do something about his problem. This has been coupled with adequate medical facilities for rehabilitation, and the long years of employment serve as a lever.

There are three basic steps in the operation of the Procedure on Alcoholism: Recognition, Rehabilitation, and Disposition of Relapse Cases.

RECOGNITION

The foremen and supervisors have the responsibility for recognizing the signs of uncontrolled use of alcohol among men working under them. While the Medical Department does not have the responsibility of discovering alcoholics, it does play a role in the early recognition of a drinking problem which masquerades as a medical illness. This recognition procedure is backed up by a training program. It is used to periodically instruct the supervisory group in understanding the objectives of the Company procedure and to assist them in recognizing the early signs of problem drinking. It is interesting to note that whenever the training program is intensified, there is a corresponding increase in the rate of recognition.

When a problem arises from repeated excesses, the employee is interviewed by his supervisor and placed on probation. As a practical matter, this requires preliminary warnings which are incorporated in the record. The union is notified of this action, and if the employee requests it, a shop steward is present at this interview. A detailed written report of all the circumstances is forwarded to the Medical Department. The employee, during his interview, is advised that information he conveys to the examining physician may *not* be considered a privileged communication.

REHABILITATION

Responsibility for the diagnosis of alcoholism and for the supervision of the medical follow-up of rehabilitation lies with the Medical Department. The employee is offered the opportunity for rehabilitation through the Consultation Clinic for Alcoholism at University Hospital. On the other hand, he may choose to report to Alcoholics Anonymous, place himself in the care of his own physician, or even refuse to follow any recommended treatments. In any event, the employee is scheduled for periodic revisits to the Medical Department over a period of three to four years. The operating departments also have a responsibility in the follow-up program in that they must keep abreast of the employee's current progress as evidenced by work performance and behavior.

DISPOSITION

If the drinking offense recurs, the employee is immediately suspended by his department and the Disability Panel is convened for adjudication of his case. At the panel, after all information has been presented and evaluated, the department renders its decision.

Although alcoholism is treated as

a medical condition, it gets no disproportionate share of attention. The means are provided to discipline and even discharge the offender whose problem does not seem to be related to an underlying psychological or medical situation.

When recurrences indicate an inability to cope with chronic problem drinking, or there is an underlying disease resulting from chronic alcoholism and the prognosis is poor, the employee is recommended for disability retirement. Where there is a reasonable evidence of recovery and the employee shows every intention of facing his problem, a single relapse in drinking is not always the occasion to deny him another chance at rehabilitation. We have found, as treatment improves, the necessity for disability retirements is reduced.

Our experience under the Procedure on Alcoholism can be divided into two periods: The first from January 1948 to December 1951, and the second since January 1952, when the facilities of the Consultation Clinic for Alcoholism at the University Hospital became operative. A major shortcoming in the first period of our program was the lack of medical facilities for adequate rehabilitation. Though some persons derived great benefit from Alcoholics Anonymous they were relatively few. Convinced that the experience of our own internal program indicated the need for a special treatment center, top management at Con Edison underwrote the cost of launching a rehabilitation center known as the Consultation Clinic for Alcoholism at the University Hospital of the New York University-Bellevue Medical Center. The clinic was formally opened in February 1952. Since then, approximately 20 companies have taken the opportunity to refer problem drinking cases to the Center.

The Consultation Clinic combines many disciplines in internal medicine, psychiatry, industrial medicine and psychological evaluation. Treatment consists of a type of group therapy and attempts are made to obtain an understanding of the alcoholic in regard to his immediate problems with drinking. Without getting into the specific medical detail, our doctors tell us that efforts at a deep type of psychotherapy are avoided. They feel that the treatment is best carried on outside the Company setting, since it is most important that the confidential nature of the doctor-patient be maintained. No reports are required from the clinic. Although Con Edison underwrites the annual budget of the clinic's professional and secretarial payroll, personnel, equipment and overhead, the patients themselves are expected to pay the cost of individual clinic visits which are set at a fee of $2.50 per visit.

Five-year Follow-up

The follow-up results of rehabilitation have been shown to be a long-term affair. Our medical people have learned that the minimal period of follow-up should be at least five years. Even after termination of direct Medical Department follow-up, the patient's progress is observed by review of his medical record through the fifth year.

From an operating point of view, the department keeps an employee on indefinite probation and is also responsibile for recognition of any relapse. It has been our experience that with long-term follow-up the percentage of rehabilitated patients does fall off year by year until the fifth year. The figures in the original group of 1948-1951, before there was any special medical treatment, showed that approximately 40 per cent

were able to maintain their jobs. In contrast, those who had the advantage of medical treatment show that closer to 60 per cent were rehabilitated. The overall evaluation of cases from 1948 through 1961 reveals a rehabilitation rate of 53 per cent. An interesting feature of this study is that the evaluation by the operating departments of the progress of employees on the Company's Alcoholism Procedure closely approximates the medical statistics.

A research program was initiated a year ago at the Medical Center, sponsored jointly by Con Edison, Metropolitan Life Insurance Company, the George F. Baker Trust Fund and the James Foundation, aimed at deepening our understanding of the nature and causes of alcoholism.

Originally, it was planned that research would examine any physical aspects relating to alcoholism, but after a review of the scientific literature and consultation with research specialists, the program is focusing more on an investigation of the interrelationships between personality factors, other adjustment patterns and drinking problems.

In summary, the facts that I have presented proclaim management's interest and support and indicate that a Company program is a positive step toward the prevention of disability from chronic alcoholism. But is is only a first step. It is essential that a complete understanding and an unreserved acceptance of the Company program be obtained at all levels of management.

A well defined policy should form the practical basis for administrative procedures to cover early recognition, rehabilitation, and a consistent method for terminating employment when efforts to effect rehabilitation are unsuccessful.

From an industrial relations standpoint, recognition of the alcoholic remains the major defect. Training of supervisors should be implemented and employee education expanded. In companies with organized unions, the development of a Company program should be associated with sufficient information to the union so that they can understand the objectives of the program. In other words the establishment of good faith is most important. The opportunity for rehabilitation is the best evidence of good faith.

The lack of medical knowledge about alcohol addiction is still a real stumbling block to adequate medical treatment. Research funds are needed for study in the area of pharmacological and physiological investigation rather than all being spent in further study of the social and cultural aspects of problem drinking.

Accent on Research

A greater effort should be made toward organizing rehabilitation clinics. This is not to depreciate the achievements of AA, but since chronic alcoholism is a medical condition, let us make a medical approach to the problem with the accent on research. As I have indicated, it is our personal feeling that the combination of medical treatment and AA offers the best hope for rehabilitation at our present level of knowledge.

The ultimate goal of any Company procedure should be the prevention of disability from chronic drinking. The good results of industrial programs actually in operation have shown that these efforts not only yield material rewards in salvaging the skill and experience of long service employees and save money but also contribute to an over-all improvement in employee relations.

A company program including a straight-forward policy toward alcoholism, treatment for alcoholic employees, and the training of supervisors could do much to help clarify and strengthen supervision's role.

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The Employed Alcoholic

BY HARRIS M. TRICE, PH.D.
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CERTAIN background information is helpful before looking closely at the job behavior of the alcoholic employee. We know, for example, that he is usually employed during most of his illness. Thus in the early and middle periods of alcoholism, even when approaching the full-blown, chronic, late period, he typically continues to work. Also, he appears to be rather evenly distributed among various occupations and industries. All levels of management and the professions have their share. But the alcoholic employee is concentrated in those age and sex categories where his impact as a personnel problem is great. Thus he is lodged in the productive years—35 to 50—and is still predominantly male—among the traditional "breadwinners." Despite speculation about there being as many female as male alcoholics, there is still no evidence to disprove the "maleness" of the problem—especially in the work world.

Frequently the alcoholic has been a very capable employee. Often he is a longtime one. He seems to be at all levels of employment, skilled and unskilled, top management and first-level supervision. For practical purposes we can use the figure of 3 percent to estimate his probable number in any particular company. Certainly this varies up or down with specific conditions such as sex ratio, or age distribution, but it is still a good modal figure. And, though an overall estimate of his cost to industry is almost impossible to make, we can be sure he has a sharp impact and cost: his various forms of absenteeism, combined with poor work, are obviously costly. The impact on his immediate boss is apparently much greater than other behavior disorders because it produces a frustrating "never know what to expect" in

one who was probably at one time a good man.

Against this broad background we can look more closely at the specific job behavior of the alcoholic employee. First, there seems to be little doubt that work performance suffers, especially as his alcoholism moves into its middle period. Up to that time he has struggled desperately to keep the job from being affected. It is his last way to prove to himself and those around him that "nothing is wrong." So his job deterioration is often marked by a cyclical job pace, by desperate spurts to make up for poor work due to hangover symptoms or "partial absenteeism." If he is in an executive job, his poor job performance will be an undramatic matter; he is typically present, but suffers badly from "on-the-job-absenteeism." At high status levels the classic "half-man" is found. At "operative" levels his poor work is related to "going on and coming off one."

Absenteeism

Employers have no great reason to believe the alcoholic employee is a "job hopper." They can expect to retain him at about the same rate as non-alcoholic employees in the same occupation. But his absenteeism is something unusual, both in kind and amount. During early symptoms he makes an heroic effort to avoid absenteeism. As his illness progresses, however, it occurs in a rather unusual way. He goes to work, but engages in various kinds of "partial" absenteeism after he gets there; he leaves his work post rather frequently, is apt to take longer lunch hours and is more prone to leave work in the middle of the day. As his illness progresses, however, he begins to engage in real "off-the-job" absenteeism—especially if he is employed in non-managerial and non-professional jobs. Within a few years this typically reaches two or three times the ordinary sick absence rate. On low-status jobs this traditional form of absenteeism seems to be especially apparent as the alcoholic moves into the middle period of the malady.

In contrast to absenteeism, however, is a lack of on-the-job accidents, especially as he moves into alcoholism. The evidence is somewhat fuzzy about the very early period of alcoholism, but seems to be rather clear about middle-stage alcoholism, namely, there does not seem to be any unusual on-the-job accident rate for alcoholics. This conclusion coincides with the psychological reaction of many alcoholics. They become extra cautious. They absent themselves when they believe they would be most likely to have an accident. They develop a routine whereby they anticipate the results of alcohol, if they drink during the work day. In short, they are trying to prevent at all costs a discovery of their real problem. At first, they avoid absenteeism and poor work performance, but as their developing illness produces such visible results, they attempt to avoid the most obvious sign of all—lost-time accidents.

Finally, the alcoholic has cover up experiences on the job. Efforts are made by someone to prevent his condition from coming to the attention of management. There are four possibilities: no cover up at all, the developing alcoholic himself does it; his peers do most; his immediate boss does it; or in the case of management personnel, his subordinates do it. It is rather clear that the alcoholic employee himself does most of the cover up with peers and subordinates a poor second. In other words, whenever we hear "cover up" mentioned we can think pri-

marily of the efforts of the alcoholic to prevent his condition from being known. He is in many ways a "cover up artist."

To a large degree all these job behaviors of alcoholics vary by job status. Thus the way job performance declines as the illness progresses varies sharply between executive alcoholics and semi-skilled ones. Absenteeism, of the traditional "off-the-job" kind, seems to be a part of a low-status alcoholic's work pattern, but not of a high-status one. The turnover pattern of alcoholics follows the typical occupational rate of the job—thus the high ranked alcoholic remains on a job for a very long time whereas a low-status one may have many job changes in keeping with his occupational pattern. Finally, the cover up experiences of executives and other high-status alcoholics seem to be largely self cover up on the job, while operatives and laborers experience very little cover up at all —everyone knows it.

Immediate Boss

Against this background of general and specific job behaviors of the employed alcoholic, it is appropriate to look at his immediate boss who is the "key" non-alcoholic in the work world who deals with him. The brunt of the alcoholism on the job is borne by him. He is the one who is often characterized as engaging in wilful cover ups or as being so unaware of his employees that the alcoholic is "hidden" from him.

Actually, neither of these notions describe him. Perhaps he is unaware of his alcoholic employee in the earliest period of the illness. But he soon notices him, although he does not always realize the significance of what he observes. Probably the chief clues of what begin to be noticeable to the immediate boss of an alcoholic are the forms of "partial" absenteeism, especially unauthorized departure from his work post for a sizeable period during the work day.

Presently, he is confronted by the kind of absenteeism that is a more difficult problem—the traditional, "off-the-job" kind. He becomes acutely aware of him when the alcoholic turns to daytime drinking as a way to handle his problems. He detects the smell of alcohol or breath purifiers. He notices red or bleary eyes very easily. The alcoholic employee becomes very "tricky" at avoiding him. The boss may be too busy to notice the before-work morning drink. But he may note the sharp personality change after lunch-time drinking which often brings with it rather loud talking and generally relaxed, uninhibited behavior. In short, the boss may miss the more subtle, very early signs, but he is certainly apt to see those somewhat later signs.

Not only is it misleading to speak of the alcoholic employee as "hidden," but it is also inaccurate to describe the boss as "covering him up." It is far more accurate to describe him as being on a "seesaw." He may cover up for a short time, but soon he is pressured in two directions at the same time—toward helping the employee manage his problem on the one hand, and toward reporting him on the other. It adds up to classic indecision. Most bosses of alcoholics are ripe for help from their companies and usually welcome a way out of their dilemma.

He does not engage in deliberate, wilful concealment of the alcoholic. There are definite pressures playing on him to use an alcoholism program if one be present. But there are others, almost equal in strength, pressing him not to use it.

What are these conflicting pres-

sures? First, there are the positive ones—those pushing him toward "doing something." It is the supervisor's job to get a "full man for a full day." So the boss is forced to watch over, supervise, check up on, and plan more closely, the entire work of the alcoholic employee. There is the increasing problem of absenteeism. On more than a few occasions the boss has to find replacements "on the spur of the moment." This can be irksome and disruptive.

But it is lack of predictability of the alcoholic employee that adds "fuel to the fire." The boss never knows what to expect from him. He can't count on him compared with other subordinates. All this makes the boss uneasy. He becomes worried because the problem-drinking employee may well put him in a "bad light." If he does too much to protect him, or if he fails to report him, he is "putting the noose around his own neck." He is further aggravated by the bad effect the alcoholic employee has on other employees. Often his work piles up on them.

From this description it seems the immediate boss would not hesitate to take some form of action—there are still other reasons not to hesitate. But he does hesitate, and often with good reason. Probably the foremost is the desire of the boss himself to help the developing alcoholic overcome his drinking problem. He reasons that it is the duty of a good supervisor to take an interest in his worker's problem. To do otherwise would be an admission of failure as a supervisor. In short, he believes he can do as good a job as formal therapy. For that matter, who is to say that he cannot? Suffice it to say that this attitude stands in the way of his referring his alcoholic. Often he chooses to "go it alone."

Then, too, the boss tends to believe that to get treatment or help of some kind is a matter of last resort after everything else has failed. Like many others he has the stereotype of a late-stage, near skid-row type in mind—a left-over from the bitter "wet-dry" struggle. So the employee must be showing symptoms consistent with this late-stage image before he is, in the mind of the boss, eligible for formal action. If and when the fellow gets that bad, the boss figures he should be turned over to the medical department or some welfare agency. In the meantime the boss says, "I will do all I can to help him, *not* label him." In essence, this is a supervisor fulfilling the general role of the boss. He is deliberately trying to meet the expectations of such a role. Other factors buttress these reasons for reluctance, but the two described give a clear notion of the manner in which the boss of an alcoholic is "torn both ways."

Straight-Forward Policy

Thus, in broad outline, the immediate boss tends to be aware of alcoholism in an employee at a fairly early stage, but is quite undecided what to do about it. In practical terms this means that a company program including a simple policy, available treatment, and top management support helps out supervision in its role. They are seeking a way out of a painful dilemma. If management will develop a straight-forward policy recognizing alcoholism as a health problem and providing treatment help just as it does for other major illnesses, it will provide their supervisors with "a way out." And, if it will train supervision realistically about alcoholism, tailoring training content to the frame of reference of supervisors, the twin notions of "hidden" and "cover up" can be effectively reduced.

What to Say to an Alcoholic

BY A RECOVERED ALCOHOLIC

The author discusses an approach the supervisor may take to provide the alcoholic employee an opportunity to admit, accept and attack his illness while he continues working.

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THE business world now accepts four facts about alcoholism and the alcoholic.

1. Alcoholism is an illness, not a moral problem.
2. It can be treated.
3. The alcoholic is worth treating.
4. He himself is the last to recognize or to accept his problem.

Most articles on the subject are considered complete once these facts are put across.

This article deals solely with the approach an executive may take to give the already pegged alcoholic an opportunity to admit, accept, and attack his illness—and remain on staff.

There is a fine distinction between the heavy drinker who doesn't allow his drinking to interfere with his business life and the probable alcoholic who gives continuous evidence of never allowing his business activities to interfere with his drinking.

There is never a "right" time to discuss excessive drinking with an alcoholic employee. If he is sober, then one hesitates to remind him of past distress. If he has a hangover or is drunk, his reactions are not responsible and discussion will be futile.

Confronted with the prospect of the drinker's guilt, resentment, defiance, or excuses, the manager usually falls back on the hope that a small reprimand for lateness or hangover or carelessness will lead the drinker to mend his ways.

But alcoholism is not this easily licked. And it is a progressive illness that never gets better, only worse.

If you have an alcoholic on your staff, you may say to yourself: "Do I have the right to invade this man's privacy?" A little thought should make you realize that his drinking on or off the job is no longer a

private matter. Both *your* job and the staff's morale are affected.

In any event, the responsibility for handling the problem will probably end up in your lap. It's true that the company medical department — if there is one—may be able to help. But often the employee will simply ignore its advice or warnings. If your man is one of top management, it is unlikely that the medical department will openly label him as alcoholic.

If you've sent the man for medical attention and his drinking continues to interfere with his work to the point where you see the inevitability of his eventual failure, you must take action. Talk to him at the very first moment you feel up to it and he's sober enough to listen. Ask him into your office or outside for some coffee, and lay it on the line.

What do you say to him? Resign yourself to the fact that no matter what you say, the interview will be unpleasant. You may get excuses, rage, or lies. But if *you* don't weasel, the alcoholic is more likely to take what you say.

First, let's consider what you *shouldn't* say. Don't apologize for bringing up the problem. Never get involved in a discussion of "a man's right to drink." Alcoholism is not a moral problem—it is an illness.

Don't urge him to be "moderate." Comments like, "Aren't you drinking a little too much?" or "Why don't you stick to beer?" or "Why don't you save your drinking for weekends?" are useless. He knows he has progressive trouble with drinking that no amount of slowing down or tapering off will fix. He's already tried these measures—and they don't work.

The "scare" technique is equally futile. Don't tell an alcoholic that

You must convince the alcohol

he'll die of liver trouble if he doesn't lay off the bottle. He's always heard of someone who drank a quart a day and lived to be a hundred.

Your main problem in talking to him will be to answer—ideally, before he even voices them—all the excuses and tricks he will use to avoid facing the issue. What is that issue? Simply this: His *drinking*—and nothing else—is causing problems in your operation. Not his troubles with his wife or his ungrateful children or his bad back or his money problems. It's his drinking that is responsible for his lateness, his carelessness on the job, his postponement of decisions, his absences, and the demoralization of the rest of the staff. And you cannot afford to let it go on.

With this approach, you ruthlessly pinpoint the corner into which he has painted himself and force him to realize he must do something about his drinking to keep his job.

You might start out this way: "Your drinking is causing so much trouble among the staff that I have to tackle the unpleasant task of discussing it with you. You've covered your late arrivals and early departures pretty well by appearing to be constantly on the move. But not well enough. No amount of ingenuity can hide indecisiveness, erratic behavior, delays, and unavailability for very long. Work requiring only your signature never gets put through on time because you're doing some 'creative planning' in the nearest pub and don't get back, or you're afraid to commit yourself because your judgment's so shaky. People around here seem to know that you're too edgy to be approached

hat he must do something about his drinking to keep his job.

until after lunch, and by then it's a little foggy out. I want you to know that your job is at stake unless you can give me definite evidence that you are willing to find out whether or not you are an alcoholic and not just inadequate to your job. By evidence I mean taking steps such as consulting a psychiatrist or investigating Alcoholics Anonymous. And immediately."

Watch out if the alcoholic quickly agrees to see a psychiatrist, because this can be simply another evasion. He may feel he can talk about his mother or his loneliness or his frustrations and continue to drink as long as he seems to be exploring the causes of his problem.

Forestall this by saying: "About psychiatric help. Friends of mine who are recovered alcoholics tell me that delving into the causes of your excessive drinking won't help you stop the progression of this disease any more than knowing why you have a leaky heart valve will permit you to run upstairs."

At this point, you're knocking out one of his props. He has been hoping that if he found out why he drinks too much, he could correct the situation and drink "the way he used to."

Continue this way: "Ex-drinkers tell me that alcoholism is not just a problem of drinking while under stress. They tell me that a lack of love or money problems or a nagging wife merely aggravate the illness. They don't cause it. We all have emotional problems that might be helped by psychotherapy. But drinking is not just an emotional problem plus liquor. Alcoholics have a physical response to alcohol that more often than not creeps up on them—and once it does, they cannot control it by limiting the amount they drink or changing their attitudes or their living or working conditions. Just as the diabetic has to learn to live without sugar—so the drinker with a drinking problem must learn how to live without liquor. Any liquor."

The employee will now begin to realize you know more about his past and his future than he's been willing to admit. He has hoped that he could "get away with a few more years" before having to do something. You are forcing him (without your ever saying that *he* is an alcoholic) to acknowledge that inevitably he must tackle the problem of how he can stop drinking. Until now, he has only toyed with the idea of being able to control it.

Don't be thrown by stoppers like these:

1. The employee may quickly interrupt your discussion of psychiatric help for him by stating that he already goes to a psychiatrist who has never mentioned drinking as one of his problems.

Your answer is: "Indecisiveness and bad judgment may not be matters of immediate concern to your psychiatrist. They are to me. He may not care about the vodka that 'leaves you breathless' while your dreams get bigger and your action gets less. I do. He's exploring other problems. But he might address himself to this one if he knew your job was in jeopardy because of it. And it is."

2. Or he may say that he has been to a psychiatrist who has explored his drinking with him and has reassured him that, once his major

(Continued on page 30)

A feature designed to help you keep posted on developments in the field of alcoholism.

NEW BRUNSWICK, NEW JERSEY: Smithers Hall, the new home of the Center of Alcohol Studies at Rutgers, the State University, was dedicated recently. Ceremonies marking the occasion were held in the Physics Auditorium on the University Heights campus in New Brunswick. A tour of the new building followed the ceremonies.

BOSTON, MASS.: Two North Carolinians conducted the morning session at the Boston Committee on Alcoholism's Fifteenth Conference on Alcoholism on May 6. Dr. Norman Desrosiers, medical director of the Alcoholic Rehabilitation Center at Butner, spoke on "Alcoholism Treatment by Cooperating Disciplines" and Reverend Jody Kellermann, Director of the Charlotte Council on Alcoholism, spoke on "Pastoral Counseling—the Focus of Community Concern."

PRAGUE, CZECHOSLOVAKIA: Since the first anti-alcoholism clinic opened at the Charles University Psychiatric Clinic 15 years ago, it has grown from ten to 108 beds. There are also 150 other clinics throughout the country serving a total population of about 14,000,000.

RALEIGH, N. C.: During the months of June and July the Education Division of the N. C. Department of Mental Health will join with East Carolina College and Winston-Salem Teachers College in conducting Summer Studies on Facts About Alcohol. The course at East Carolina will be held from June 18-30 and the one at Winston-Salem is scheduled from June 16-July 3.

The Summer Studies are designed especially for teachers and prospective teachers whose responsibilities include teaching about alcohol. The course of study, which carries college credit, should give those who attend a better understanding of the sociological, physiological and psychological problems which arise through the use and misuse of beverage alcohol.

Lecturers will include North Carolina's foremost authorities on the study of alcohol and related problems.

Other summer studies scheduled to be held include the second annual Summer School of Alcohol Studies, for professional persons interested or working in the field of alcoholism, at the University of North Carolina June 7-12 and a five-day course entitled "Mental Health in the Community" to be held at St. Andrews College July 5-10. The latter will be composed of four-member student teams representing various communities throughout the state. Each team will consist of a teacher, a social worker, a public health nurse and a law enforcement officer.

GRAND FORKS, NORTH DAKOTA: The Sixth Annual Summer School of Alcohol Studies at the University of North Dakota will be held June 7-12. The school is designed for both professional and lay people and endeavors to present, among other things, the latest scientific information about alcohol and its use and to provide information, materials and techniques for instruction about alcohol in the home, church, school and community.

ALCOHOLIC PHYSICIANS: A medical degree confers no built-in immunity to alcoholism. The secretary of International Doctors in Alcoholics Anonymous estimates that one in every 25 doctors may be a true alcoholic and one in ten a potential alcoholic. Like other alcoholics, the physician must seek help for his illness.

CHAPEL HILL, N. C.: A recent study conducted by W. S. Pearson of "hidden" alcoholism in a general hospital took place at North Carolina Memorial Hospital, where 100 patients under treatment for unrelated illnesses were given a test interview concerning alcoholism. They were asked 6 questions concerning their personal drinking history on the subjects of morning drinks, loss of jobs or friends due to drinking, blackouts, sneaking or gulping drinks, loss of control and hospitalization due to drinking.

If those interviewed answered four or more questions affirmatively they were considered to have possible involvement in alcoholism. In the group of 100 were 62 medical patients and 38 surgical patients. In the medical group 41 were considered definitely not alcoholics; in the surgical group 21 were ruled out. Remaining were 38 patients whose answers indicated that probably 29 of them were alcoholics and nine were "suspected" alcoholics. Of the 38, only 12 charts mentioned alcoholism. The 26 remaining patients were "hidden."

The conclusion reached suggests that hidden alcoholism among general hospital patients is much more frequent than is generally thought, but it is thought that clues to an accurate diagnosis of the illness are familiar to a large majority of physicians.

RALEIGH, N. C.: By virtue of having the highest number of active Alcoholics Anonymous groups in separate prison facilities, the N. C. Prison Department has achieved the number one ranking, among states, in prison alcoholic rehabilitation. The forty-three groups active at present are the result of efforts of literally hundreds of AA members and professional people throughout the state who have supplemented the work of the N. C. Prison Department's Division of Alcoholic Rehabilitation.

MONROE, LOUISIANA: "Alcoholism—Community Responsibility" was the theme of the Monroe Institute of Alcohol Studies held in Monroe, Louisiana May 6-8. The purpose of the institute, which is planned for individuals who have a professional interest in alcohol problems and for other interested citizens, is to study and discuss current developments in education, research, advances in treatment and rehabilitation, and social action.

ALCOHOLIC ADMISSIONS: Alcoholic admissions to Maryland's state mental hospitals have doubled in the past three years—from approximately 1,100 in 1960 to 2,200 in 1963. Alcoholics accounted for 30.4 per cent of all admissions in 1963, including more than two of every five male admissions and one of every ten female admissions. Because alcoholics receive relatively short-term treatment, they occupy only about five per cent of all state hospital beds at any given time.

problems are resolved, his drinking will slow down.

Your answer is: "Your job rides on you attacking your *drinking* problem. And I suggest you discuss this with your psychiatrist, who may, in the light of this fact, want to reconsider the kind of priority he gives to it."

While he is still relieved that you don't consider him a moral weakling but the victim of an illness, you should move in fast to show you understand the colossal effort that living without liquor demands:

"It's a little like asking a man with two broken legs to throw away his crutches and walk. But with help from those who've done it, my friends in AA tell me that just knowing that one can't drink at all is a relief. The enemy is well defined. The problem is no longer a question of switching from rye to beer or gin to brandy. They tell me that any alcoholic can give up liquor for a while. All of them have been on the wagon. But this is no test of alcoholism. What they're saying is that the alcoholic's trouble lies in taking it; not leaving it alone."

Now you must cope with the employee's objection to AA. He may believe that AA's are religious fanatics. Or he may feel they are unsuccessful, drunken bums. He may think he'll have to take a pledge and live among those who despise drinking.

Wipe away these misconceptions about AA. If you don't, he'll never get through the door.

"I'd always figured alcoholics were just down-and-out bums. But that's because I only saw the ones who weren't able to do something about it. Now I've been to an AA open meeting, and I was amazed to see people from all levels of society and business—bank executives and marketing men, truck drivers and sales girls, editors and lawyers—freely exchanging information about how to lick alcoholism. Incidentally, about one-third of the people there were nonalcoholics: friends, wives, husbands, bosses, doctors, and sociologists."

This is new to the drinker. He realizes now it's possible to go to a meeting and merely be an observer, just as you did. Another prop is knocked down.

Continue to break down his resistance:

"AA's don't take a pledge. They just stay away from liquor a day at a time. They play a delaying action, while they're learning the techniques of having fun and a regular social life without drinking. They don't hate liquor. These are the guys who love it. They've just learned that it's poison for them, despite the fact that for years it looked like their only means of coping with life."

The alcoholic will think at this moment that even if it worked for him—and he'd *like* to know how to turn down a drink gracefully—he might turn into a bore and a problem for his friends, who would feel embarrassed to drink around him. He'll worry about how he'll be able to get through this weekend without the martinis or beer or bourbon that are so much a part of social life on every level.

But you must now withdraw as an authority. Tell him you only know what your alcoholic friends have told you and shown you. Tell him that they alone know how to make "not drinking" (for the alcoholic) a more challenging and exciting activity than drinking. They alone have the experience of dealing with society's pressure to drink. They alone know how to turn these adversities to their own advantage.

The alcoholic employee may not yet believe it possible for him, but he'll know you care about what happens to him and he'll respect you for being honest with him and for subjecting yourself to what he recognizes as a most unpleasant task.

You now should make it possible for him to meet an AA who will take him to a meeting. (Several names should be available to you by phone after you attend a local AA session.) Or ask the employee if he'd like you to go along with him. If he refuses your help and says that he will "think about it," then you must withdraw any further pressure upon him for the moment. If he does go to an AA meeting with you, stay in the background. Don't express opinions about the meeting or his illness. You are now an outsider. He is the one who belongs; he is the expert.

If he joins AA and then has a "slip"—a return to drinking—be understanding and support his return to the AA group. Very often, after a year or two without drinking, the alcoholic feels so good that he doubts he ever really had this problem. He will then test his ability to drink with safety. Or because abstinence no longer gets attention after the honeymoon stage of his early recovery, he will start to feel deprived of the "fun" and irresponsibility he enjoyed when drinking. When he forgets the pain, he may rationalize, "just one never hurt me." AA's look upon this slip as merely another step in the therapy and hope that it will prove to the man that he is constitutionally unable to drink. More often than not, the slip convinces the drinker that he must accept his alcoholism.

As his boss, remember, you may be able to reach the alcoholic where others have failed. Isn't it worth a try?

A NEW CAGE

CONTINUED FROM PAGE 11

types of force. Forcing an alcoholic to get help can be good or bad, depending on how well we accept alcoholism as an illness. If force means a demand that the patient give up the symptoms of alcoholism, it will probably fail. If force is a loving pressure toward treatment for the real problem, it can help. Many times we protect the patient from the "side effects" of his "do-it-yourself medication," and our intentions are good. Withdrawal of this protection may permit these side effects to force the patient to treatment. Good intentions may cause bad results.

Sometimes we cannot tolerate the symptoms of alcoholism and we do not have the strength or the wisdom to force treatment. The question then is, "Will I let this illness wreck my life while I cling to a hopeless hope that my alcoholic will 'snap out of it?' "

Decisions to break with an alcoholic are not easy. They need not be permanent. Idle threats or threats under duress can also be habit-forming. The firm decision to break may well be the turning point for acceptance of treatment. It's best if we don't burn our bridges behind us, but there are times when a break is best for all concerned.

This is a "cage building" article, not a "how to rescue" article. No one can tell us what to do about our alcoholic. A good counsellor can help us think through our decisions, but not make them for us. If we can build a new cage with the full understanding that the alcoholic is more than his symptoms, we have taken a giant step toward building a more adequate cage. Decisions are easier for the person who can realize that "there is a man inside."

DIRECTORY OF OUTPATIENT FACILITIES

for

ALCOHOLICS AND/OR THEIR FAMILIES

Competent Help Is Available At The Local Level

Key to Facility and its Service

***Local Alcoholism Programs**

for
(Alcoholics and Their Families)

—Education
—Information
—Referral

†Mental Health Facilities

for
(Alcoholics and Their Families)

—Outpatient Treatment Services

‡Aftercare or Outpatient Clinics

for
(Alcoholics who have been patients of the N. C. Mental Hospital System)

—Outpatient Treatment Services

ASHEVILLE—

**Educational Division, Board of Alcohol Control;* Mike Dechman, Educational Director; Parkway Office Building; Phone ALpine 3-7567.

†*Mental Health Center of Western North Carolina, Inc.;* 415 City Hall; Phone: ALpine 4-2311.

BURLINGTON—

**Alamance County Council on Alcoholism;* Margaret Brothers, Executive Director; Room 802, N. C. National Bank Building; Phone: 228-7053.

‡*Outpatient Clinic;* Alamance County Hospital; Hours: Wed., 9:00 a.m.-4:00 p.m.

BUTNER—

‡*Aftercare Clinic;* John Umstead Hospital; Hours: Mon. Fri., 9:00 a.m.-4:00 p.m.

CHAPEL HILL—

†*Alcoholism Clinic of the Psychiatric Outpatient Service;* N. C. Memorial Hospital; Phone: 942-4131, Ext. 336.

**Orange County Council on Alcoholism;* Dr. D. D. Carroll, Director; 102 Laurel Hill Rd.

CHARLOTTE—

**Charlotte Council on Alcoholism;* Rev. Joseph Kellermann, Director; 1125 E. Morehead St.; Phone: FRanklin 5-5521.

‡*Mecklenburg Aftercare Clinic;* 1200 Blythe Blvd.; Hours: Mon.-Fri., 8:00 a.m.-5:00 p.m.

†*Mental Health Center of Charlotte and Mecklenburg County, Inc.;* 1200 Blythe Blvd.; Phone: FRanklin 5-8861.

CONCORD—

†*Cabarrus County Health Department;* Phone: STate 2-4121.

DURHAM—

‡*Aftercare Clinic;* Watts Hospital; Hours: Tues. and Fri., 2:00-5:00 p.m.

**Durham Council on Alcoholism;* Mrs. Olga Davis, Executive Director; 602 Snow Bldg.; Phone: 682-5227.

FAYETTEVILLE—

†*Cumberland County Guidance Center;* Cape Fear Valley Hospital; Phone: HUdson 4-8123.

GASTONIA—

†*Gaston County Health Department;* Phone: UNiversity 4-4331.

GOLDSBORO—

‡*Outpatient Clinic;* Cherry Hospital; Hours: Tues. and Fri., 10:00 a.m.-12:00 noon. Thurs., 2:00-4:00 p.m.

**Wayne Council on Alcoholism;* A. T. Griffin, Jr., Executive Director; P. O. Box 1320; Phone: 734-0541.

GREENSBORO—

**Greensboro Council on Alcoholism;* Worth Williams, Executive Director; 216 W. Market St., Room 206 Irvin Arcade; Phone: 275-6471.

†*Guilford County Mental Health Center;* 300 E. Northwood St.; Phone: BRoadway 3-9426.

†*Family Service Agency;* 1301 N. Elm St.

‡*Outpatient Clinic;* 300 E. Northwood St.; Hours: Mon. and Thurs., 5:00-10:00 p.m.

GREENVILLE—

†*Pitt County Mental Health Clinic;* Pitt County Health Department, P. O. Box 584; Phone: PLaza 2-7151.

HENDERSON—

**Vance County Program on Alcoholism;* Dr. J. N. Needham, Director; 2035 Raleigh Rd.; Phone: GEneva 8-4702.

HIGH POINT—

†*Guilford County Mental Health Center;* 936 Mountlieu Ave.; Phone 888-9929.

JAMESTOWN—

**Alcohol Education Center;* Ben Garner, Director; P. O. Box 348; Phone: 883-2794.

LAURINBURG—

**Scotland County Citizens Committee on Alcoholism;* M. L. Walters, Executive Secretary; 308 State Bank Bldg.; Phone: 276-2209.

MORGANTON—

‡*Aftercare Clinic;* Broughton Hospital; Hours: Mon.-Fri., 2:00-4:00 p.m.

NEW BERN—

**Craven County Council on Alcoholism;* Gray Wheeler, Executive Secretary; 411 Craven St., P. O. Box 1466; Phone: 637-5719.

*†*Psychiatric Social Service,* Craven County Hospital; Phone: 638-5173, Ext. 294; Hours: Mon.-Fri., 9:00 a.m.-5:00 p.m.

NEWTON—

**Educational Division, Catawba County ABC Board;* Rev. R. P. Sieving, Director; 130 Pinehurst Lane; Phone: INgersoll 4-3400.

RALEIGH—

‡*Aftercare Clinic;* Dorothea Dix Hospital, S. Boylan Ave.; Phone: TEmple 2-7581; Hours: Mon.-Fri., 1:00-4:00 p.m.

†*Outpatient Clinic of the Mental Health Center of Raleigh and Wake County, Inc.;* Wake Memorial Hospital; Phone 834-6484; Hours: Mon.-Fri.; 8:30 a.m.-5:30 p.m.

SALISBURY—

**Educational Division, Rowan County ABC Board;* Peter Cooper, Director; P. O. Box 114; Phone: 633-1641.

†*Rowan County Mental Health Clinic;* Community Bldg., Main and Council Sts.; Phone: MElrose 3-3616.

SANFORD—

†*Mental Health Clinic of Sanford and Lee County, Inc.;* 106 W. Main St., P. O. Box 2428; Phone: 775-4129 or 755-4130.

SHELBY—

†*Cleveland County Mental Health Clinic;* 101 Brookhill Rd.; Phone: 482-3801.

SOUTHERN PINES—

**Moore County Alcoholic Education Committee;* Rev. Martin Caldwell, Director; P. O. Box 1098; Phone: OXford 2-3171.

†*Moore County Mental Health Clinic, Inc.;* Box 1098; Phone 695-7781.

WADESBORO—

**Educational Division, Board of Alcohol Control;* Robert M. Kendall, Director; 125 W. Wade St.; P. O. Box 29; Phone: 694-2711.

WILMINGTON—

†*Mental Health Center of Wilmington and New Hanover County;* 1013 Rankin St.; Phone: ROger 2-8294.

**New Hanover County Council on Alcoholism;* Mrs. Margaret Davis, Executive Secretary; 211 N. Second St.; Phone: 763-7732.

WILSON—

‡*Aftercare Clinic;* Encas Station; Hours: Mon.-Fri., 8:00 a.m.-5:00 p.m.

†*Wilson County Mental Health Clinic;* Encas Rural Station; Phone: 237-2239.

WINSTON-SALEM—

*†*Alcoholism Program of Forsyth County;* Marshall C. Abee, Executive Director; 802 O'Hanlon Bldg., 105 W. 4th St.; Phone: PArk 5-5359.

YADKINVILLE—

**Alcoholism Information Center;* Rev. James A. Haliburton, Director; Yadkin County Courthouse.

ARP EDUCATION AND INFORMATION SERVICES

INVENTORY—bi-monthly magazine using the techniques of education in presenting facts about alcoholism in popular, illustrated style.

Films—on alcohol facts and personality health for distribution among groups interested in brief, factual motion picture studies. Obtainable from State Health Department. Please request films as far in advance as possible and state second and third choices.

The ARC Brochure—illustrated booklet on North Carolina's program for treating alcoholism as an emotional sickness.

The New Cornerstones—ARP family manual giving basic facts about alcoholism and suggestions for coping with the personality sickness.

The Lonesome Road—eight sets of eight 15-minute radio narratives dramatizing the way of the alcoholic, for use on local stations.

Anyone You Know?—radio drama of the steps to alcoholism, to voluntary treatment, to rehabilitation, in 15-minute records.

Library Books—Books on alcoholism are available from the North Carolina State Library through local libraries to residents of North Carolina. To obtain any of the books listed in the March-April issue of **Inventory**, go to your community library and make the request.

ARP Staff Speakers—members of the ARP's Raleigh and Butner staffs are available for speeches before civic and professional groups.

Book Loan Service—kits containing reference books and pamphlets on alcoholism. Available to teachers from the N. C. Alcoholic Rehabilitation Program, Raleigh.

Consultant Service for establishment of local programs.

These services are free upon request of citizens residing in North Carolina. For free materials in limited quantity, write

N. C. Alcoholic Rehabilitation Program
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Raleigh, N. C.

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